Answers to questions pertaining to CHIP Administrative Services RFP

General Questions

1. When will the RFP and attachments be available on diskette or the Internet in Word format?

Answer: The RFP is available on the HHSC website in Word format. Attachments are in the process of being linked to the RFP.

2. Does HHSC plan for the vendor to use any components of the State's existing technical architecture (i.e., network, mainframe, etc.) to support the CHIP system or is the vendor expected to provide all components of the architecture?

Answer: The vendor is expected to provide all components of the architecture.

3. The RFP does not discuss claims submission or claims adjudication for eligible CHIP recipients. How is this process going to be supported and by whom?

Answer: Claims submission and adjudication are health plan issues and they are addressed in Section VIII of the health plans RFP.

4. The second part of the first question of the *Administrative Information* form provided on the Internet that is to be included in the RFP asks for "the full names (last, first, middle), addresses, telephone numbers, titles and occupations of members of the Board of Directors or any other principal officers. . . ." May proposers include only the first and last names along with the other required information or is inclusion of middle names mandatory?

Answer: Inclusion of middle names or middle initials is mandatory on the Administrative Information form.

5. The second paragraph of that part asks for the "full names (last, first, middle) and addresses for each partner, officer, and director. . . . " May proposers include only the "key" (perhaps ten or fifteen) officers? Note that there may be well over one hundred such individuals in this category.

Answer: Full names and addresses must be provided for each partner, officer, and director.

6. Is the funding allocation for this contract known? If so, please provide this information so that bidders can prepare proposals that fall within the range of available funding.

Answer: HHSC is not publishing a specific funding allocation for the administrative services contract.

7. A major concern is that, since another contractor will be doing the outreach and publicity, the administrative contractor could be penalized if the outreach piece is not successful. For example, if the outreach contractor does not meet the timelines and the campaign is delayed, how does the state plan to make referrals to the CHIP administrative contractor?

Answer: Outreach will be an extremely important priority, because poor early enrollment will be harmful to program credibility, the health plans, and the administrative contractor. HHSC does not anticipate the scenario described in this question.

8. Is the CHIP vendor precluded from bidding on the outreach contract?

   Will the successful Administrative Services contractor be precluded from submitting a proposal for the Outreach Services RFP?

Answer: The successful Administrative Services contractor is not by definition precluded from submitting a proposal for the marketing/media services RFP. But to the extent that any entity submits proposals in response to more than one CHIP RFP, those proposals will be reviewed for any possible conflict of interest. Where such a conflict is determined to exist, the proposer will be disqualified from consideration.

9. In the HMO RFP the projected caseload is expected to be 440,190 in May 2002. Is caseload precisely analogous to enrolled children?

Answer: Yes.

10. Are monthly projections of number of applications and enrollments available?

Answer: Monthly CHIP enrollment projections through September, 2005, are posted on the HHSC website under the health plans procurement. HHSC has not estimated numbers of applications.

11. Will any quality control audits be conducted by organizations outside the State? If so, who will bear the cost of these audits?

Answer: HHSC may contract with an entity to conduct a quality control audit of the administrative contractor. If this happens, the cost of the audit will be borne by HHSC or a state agency designated by HHSC.

12. Will the State conduct routine financial audits or will any such audits be conducted by private audit firms? If so, who will bear the cost of these audits?

Answer: The State reserves the right to conduct or to have conducted on its behalf by a private contractor financial audits as the state deems prudent. The cost of any such audits will be borne by the State.

13. Relative to the model contract scheduled to be on the HHSC website approximately 8/27/99: Will the contract include a provision on how the contractor can expect to be reimbursed for its implementation costs in the event the contract is terminated due to circumstances beyond the contractor's control? Will the contract include a provision on insurance requirements? Is the State willing to clarify or warrant in the contract that its information systems, and all of the systems the contractor will be required to interface with, are Y2K compliant? Is the State willing to include a provision that the Contractor shall not be liable for inaccuracies in century date data resultant from non-compliant hardware, software, or custom designed systems of custom designed software currently owned or used by the State? (Question #14)

Answer: The terms and conditions to be included in the contract will be spelled out in detail in the model contract posted to the HHSC website. Among the issues to be addressed in the model contract will be Y2K compliance.

14. Relative to the management services contract to oversee the CHIP Phase II program, please consider the following two scenarios when responding to the questions: 1) The state assigns program oversight to the Texas Healthy Kids Corporation; and 2) Texas Healthy Kids Corporation bids on and is awarded the administrative service contract. Would it be considered a conflict of interest, under either scenario, for THKC to refer children not eligible for CHIP or Medicaid back to their own organization? Would it be considered a conflict of interest for any other administrative service contractor to refer non-CHIP/Medicaid children to THKC if THKC is providing program oversight? (Question #48)

Answer: The scenario described above could not occur. Program oversight could be assigned to THKC only through the management services procurement. That RFP reads, in part: "In order to ensure objective contract management and to avoid conflicts of interest and unfair competitive advantage, any successful proposer for this RFP, including any parent or subordinate corporate entity and subcontractor, will be disqualified from competing for award of a CHIP contract in the area for which it intends to provide management services." Consequently, THKC cannot oversee the administrative contract and also be the contractor. It would not be a conflict of interest if any other administrative services contractor referred children to THKC under the terms specified in the RFP if THKC manages the administrative contract.

15. Under the administrative service contract will the State allow joint venture and/or partnership proposals, and if so, under what provisions?

Answer: HHSC will entertain proposals from joint ventures and/or partnerships. Such proposals, however, must clearly identify the parties, their legal relationship,

and which party is responsible for which tasks. Information required by the RFP must be submitted relative to each of the parties to a joint venture or partnership. In addition, any successful proposers proposing as joint ventures or partnerships must contract with the state as such, unless the state agrees to another contracting arrangement in the course of contract negotiations.

Section I(C): Term of Contract

1. Should proposals contain financial information for the option years?

Answer: Section I(C) includes the following: "Proposers may submit in their response to this RFP the terms and conditions for service in additional years." This may include application, enrollment, and/or monthly maintenance fees for the additional years.

Section I(D): Schedule of Events

1. The RFP indicates that the "deadline for submission of proposals is September 3, 1999." Several of the forms related to Historically Underutilized Businesses mention the "bid opening date." Are these the same dates? Similarly, the HUB forms indicate "notification of selection." Please define.

Answer: "Bid opening date" means the day the proposals are opened by the State, i.e. the day after the proposals are due. "Notification of selection" means the day on which the awardee is announced.

2. Will the State grant an extension of the proposal due dates from Sept. 3 to Sept. 24 for all vendors?

Answer: No.

Section I(K): Participation in CHIP Management Services Procurement

1. If HHSC decides to award a management services contract to multiple entities e.g., one to manage the HMOs and PPOs and one to manage the administrative services contractor, would the entity awarded the administrative services contract be precluded from an award to manage the HMOs and PPOs?

Answer: Yes. Section I(K) states that the administrative services contractor, "including any parent or subordinate corporate entity and subcontractor, will be disqualified from competing for award of a contract management services contract that HHSC or its designee may procure for CHIP."

2. Will all contracts, including the Administrative Services and Management Services contracts, be held by the HHSC?

Answer: HHSC will hold the contracts, though it reserves the right to delegate management of any contract to another entity, including another state agency.

3. Please specify the authority that the Management Services contractor has over the Administrative Services contractor. Will the Administrative Services contractor's responsibilities expand beyond what is stated in the RFP? Over and above what's stated in the RFP, please specify additional responsibilities that the Administrative Services contractor has to the Management Services contractor.

Answer: The administrative services contractor's responsibilities will not expand beyond what is stated in the RFP unless an amendment to the RFP is published or the additional responsibilities are agreed to within the context of a contract negotiation. For specific management services contract responsibilities vis-à-vis the administrative services contractor, proposers are encouraged to consult the management services RFP available on the HHSC website.

Section I(L): System Demonstrations

1. The RFP states that system demonstrations may be requested. The evaluation review criteria on pages 10 through 12 do not address systems demonstrations. How will the system demonstrations benefit the bidder?

Answer: There are numerous system requirements enumerated in Section VI(E), which is referenced in the "Project Scope, Work Plan, and Risk Assessment" evaluation review criteria. A demonstration of an existing system may benefit a proposer if it provides a more complete opportunity to evaluate the proposer's response to the system requirements in Section VI(E).

Section II: Program Information

1. The Agency indicates that specific criteria constituting "good cause" exceptions have not been finalized. Once this policy and other policies are determined the CHIP administrative system's business rules must be appropriately modified. What is the process the Agency intends to use with the contractor to manage and control program and system scope of work changes not specified in the RFP, proposal or contract?

Answer: The system's business rules are either specifically described in the RFP or described by inference. For instance, the business rules pertaining to eligibility will be inherent in the information contained in the application, but the RFP does not specify the relationship between the application information and the actual eligibility determination rules. The contractor will be expected to incorporate these rules into the system during the development phase as they are articulated by HHSC or its designee. Similarly, references to "good cause exceptions" mean these must be incorporated into the system as they are articulated by HHSC or its designee. The actual process of clarifying the business rules that are not specifically

described in the RFP will be developed in consultation with the contractor soon after contract execution and it will reflect the aggressive development timetable.

Section II(A): General Purpose and Background

1. The RFP states that continuous enrollment applies to the first year of enrollment, then there will be "open enrollment" periods thereafter. At what point does the open enrollment process begin? Is there any window of time that a plan change can be made? Can the PCP be changed at any time? What is the contractor's role in PCP, and plan changes? How many changes are anticipated during this period each year? Who is responsible for the notification of open enrollment?

Answer: The RFP states that open enrollment may be used. At this time, HHSC does not have a timetable for making this decision. If the decision is made to have open enrollment periods, the responsibility for notification will be clarified at that time.

Generally, a health plan selection is effective for twelve months (at which time the child is eligible for re-enrollment and another health plan may be chosen). However, the health plans must accommodate changes in health plan enrollment for exceptional reasons or good cause, such as permanent relocation to a different HMO service delivery area or a different location within a service area (necessitating a change in primary care provider). Members are allowed to change health plans the first day of the month following the month in which the exceptional reason or good cause situation occurred, in accordance with the same cut-off processing timeframes applied to new enrollees.

A member may change PCPs, and such change is effective no later than the month following the month in which the HMO received the requested change, if the change was requested prior to the cut-off date. HMOs may limit both PCP and OB/GYN changes to four times per year.

HHSC has not estimated the number of plan or PCP changes within a year. A change of health plan or PCP must be initiated with the administrative services contractor.

2. This section makes reference to client "co-pays." What, if any, role does the contractor have in determining, collecting, or tracking co-pay amounts?

Answer: The administrative services contractor's only role is in regard to the family's tracking of co-payments relative to the $100/5% cost-sharing caps. The contractor's role is described in the Cost-Sharing section of the RFP. The contractor does not have a role in determining or collecting co-pays.

3. Will enrollment be effective statewide as of 05/01/2000? Or does HHSC envision the first phase of enrollment to begin 05/01/2000, with statewide rollout to be completed in subsequent phases over 18 months?

Answer: Enrollment is effective statewide as of 5/1/2000. There will be no phase-in.

Section II(B): Program Legal Authority

1. Please describe the roles of the Agency (HHSC), the TDH, TDHS, and the TDI in the overall CHIP program.

Answer: HHSC is the agency with primary statutory authority to implement and oversee CHIP. The CHIP appropriation is also made to HHSC. The respective roles of TDH and TDHS will depend on the outcome of the management services procurement. TDI will perform the same licensure and regulatory functions in relation to CHIP plans that it performs in relation to commercial health plans.

2. If more than one Agency is involved in overseeing the administrative services contractor how will the roles be coordinated?

Answer: There will be only one entity charged with overseeing the administrative services contractor.

Section III(B): Assembly and Submission

Assembly

1. The RFP states, "The original and each copy of the proposal must be submitted unbound." Does this requirement preclude placing the proposal in three-ring binders?

Answer: The proposal may be placed in three-ring binders.

Section IV(A): Screening Proposals

1. The RFP states that proposals will be initially screened for eligibility. What criteria will be used for determining eligibility?

Answer: The criteria are described at various places within the RFP. The checklist enumerates some, but not all, of the criteria that must be met for a proposal to be deemed eligible for consideration. A careful reading of the RFP should identify all required criteria.

2. Are proposed subcontractors required to provide information requested in the "Cover Page" section in addition to the proposer?

Answer: No.

Section VI(D): Proposer Experience

1. The first paragraph of this section requests that the proposer include sufficient detail to demonstrate the relevance of their experience, including project descriptions and costs. Please explain how costs can demonstrate experience. What type of cost information is expected in response to this section of the RFP?

Answer: Cost information can aid in evaluating the scope and magnitude of a proposer's experience with a particular project. Fees, compensation arrangements, or revenues generated are several examples of the types of information that would be considered responsive.

2. The RFP states, "If the proposer has been the subject of any penalties, contract cancellations, contract terminations, sanctions, *administrative proceedings*, any type of corrective action plan(s), or lawsuits, those events must be documented . . ." (emphasis added). Does HHSC require documentation on administrative proceedings involving specific employees issues (e.g., workers compensation appeal hearings, unemployment benefit appeal hearings, etc.)

Answer: "Administrative proceedings" in this context refers to those related to contracted work and/or contracts, and/or those administrative proceedings that, if successful, would adversely affect the solvency of the proposer or its ability to continue in business.

Section VI(E)(1): Operational Issues

In-State Presence

1. Does the requirement "sufficient staff to adequately manage the project" allow corporate executive and technical staff to remain located outside the thirty-five mile radius from Austin?

   Our understanding is that the work associated with the development of the system during implementation can occur outside the 35-mile radius requirement. Can the key technical personnel reside outside the 35-mile radius during ongoing operations?

Answer: Corporate executive staff may be located outside of the 35-mile radius. As to the location of corporate or key technical staff during ongoing operations, the answer would depend on whether the proposer can demonstrate that sufficient qualified technical staff are available within the radius to adequately manage the information systems and data.

Staffing and Administration

1. The RFP refers to lockbox handling. Is the contractor required to maintain a zero balance account?

Answer: State Comptroller rules do not allow state payments to be deposited in a non-State account temporarily. State funds must be deposited directly into the Treasury and credited to the general revenue "holding account" of the appropriate state agency. This means the administrative contractor will collect the premium cost-sharing payments, bundle them, and deliver them at least once every three working days to the State Comptroller's office for deposit into the Treasury.

2. Does the Information Systems Director for the project need to be dedicated full time to the project?

Answer: No.

3. Referencing Proposal Deliverables: Should a discussion of progress reporting, which is addressed under the Staffing and Administration heading, be included as a Proposal Deliverable for this section?

Answer: A response to the "progress reporting " requirement is not a proposal deliverable.

Qualifications and Experience of Management and Technical Staff

1. This section requires resumes for key operations staff. Is it permissible to present names, qualifications, references, and resumes for our proposed implementation team, along with the assurance that operations staff not yet hired will have equal or greater qualifications?

Answer: Job descriptions for the operations staff not yet hired may be submitted in lieu of resumes.

Community-Based Organization Training

1. Is the contractor responsible for organizing the training sessions (e.g. site procurement, registration, etc.) or to conduct actual training only?

Answer: The contractor will not be responsible for logistical organization.

2. Please clarify whether the contractor will be expected to conduct only one (1) training event in each of the eight (8) locations.

Answer: That interpretation is correct.

3. HHSC intends for the contractor to train no more than two (2) representatives of each CBO. Please provide an estimate of the number of CBOs the HHSC is referring to. This additional information is required for costing and planning purposes.

   Where will the training locations be conducted and what is the expected attendance?

Answer: HHSC cannot predict the number of CBOs with whom it will contract or the number of people who will likely attend. Those numbers will be a function of the quality and quantity of the responses to the CBO RFP. The locations will be spread throughout the state, and will include San Antonio, the Dallas/Ft. Worth, Houston, El Paso, and Brownsville or McAllen.

4. The RFP states that the contractor is responsible for training CBOs on the application process. Does the contractor have any oversight or quality control responsibility related to the performance of CBOs?

Answer: No.

Financial Stability

1. The RFP states, "HHSC will require a performance bond in an amount equal to two percent of the contract's value." Please confirm that HHSC requires the performance bond to be two percent of the contract's value for the three-year base period of the contract only, and should not include values for the two-1 year options.

Answer: Confirmed.

Section VI(E)(2): Business Rules

Call Center

1. During the proposer's conference on July 30th, HHSC indicated that the CHIP administrative services vendor would become the single point of entry into Texas' health insurance system (i.e., Medicaid, CHIP, and THKC). Does this mean that all requests for medical assistance made by residents of Texas will be required to come through the call center? For example, if an individual enters an office of TDHS and requests Medicaid, will that request be forwarded to the call center? What is the anticipated volume of these applications that are expected to be processed by the CHIP vendor's call center?

Answer: If an individual enters a TDHS office and requests Medicaid, that request will be processed through DHS. However, if the applicant is denied Medicaid, the person would be given a CHIP application, and that could prompt a call to the hotline. In general, however, the call center will be the focus of the media campaign and the community-based outreach. For an estimate of the number of applications that may be processed through the call center, HHSC recommends proposers

contact other populous states with state-designed CHIP programs to learn about their historical experience.

2. The RFP states that the eligibility and enrollment hotline staff must be able to give correct cost-sharing and other financial information relating to eligibility criteria. What other financial information will need to be given to the caller?

Answer: The relationship between family size/income/asssets and eligibility for CHIP/Medicaid/THKC.

3. What frequency is the average 5 minutes or less wait time based on (daily, weekly, monthly, quarterly)?

Answer: Average daily basis.

4. The RFP states that 2 separate 800 numbers are required, one for eligibility and enrollment, the other for providers. Does the HHSC require a separate number for TDD eligibility and enrollment calls?

Answer: ??? (I think we could use one TDD number for both, but maybe there are others who can better answer this)

5. Will the administrative services contractor's toll-free member number be advertised by the media contractor as the hotline to call for applications?

Answer: Yes. The advertising message will also make it clear that people can apply over the phone by calling the toll-free number.

6. What languages, other than Spanish and English will HHSC require the contractor to support?

Answer: The RFP states that "translation services for non-English speaking callers must be available." Further, the RFP states that this requirement may be met through an arrangement with a contracted service. HHSC is not prepared to articulate all the languages that must be supported, because this will be a factor related to ongoing program management and outreach. HHSC recommends that proposers identify and budget for translation arrangements that are flexible and comprehensive.

<u>CHIP Website</u>

1. Will the web site be part of HHSC's home page or will it be a stand-alone page? With so many different entities needing access to edit a web site, who has primary management/final approval responsibility of the content for the web site?

Answer: Stand-alone. HHSC has final approval of the content and the administrative services contractor has primary management responsibility for performance of the website.

2. The RFP states that materials will be posted on the Web site in English, Spanish, and other languages. What other languages will be required?

Answer: HHSC is not prepared to articulate all the languages that must be available on the website, because this will be a factor related to ongoing program management and outreach. HHSC recommends that proposers identify and budget for translation arrangements that are flexible and comprehensive.

3. What is the state's definition of a "stable web site"?

Answer: A stable web site is reliable, permanent and consistently operational (i.e. not regularly brought down for maintenance). The site should be reliably available to clients everyday, between 8:00 AM and 9:00 PM.

4. What is meant by "editing access to the web site"?

Answer: HHSC staff (or the staff of a state agency designated by HHSC) and the marketing contractor must be able to edit the web site, through a secure process. This will enable HHSC or marketing contractor staff to directly add or edit website content without having to use the administrative contractor's staff or computers.

Client Applications

1. The RFP describes the elements that will be included on the generic application, please clarify what is meant by outreach input?

   The list of elements on the application includes "Outreach input." What is included in this term? Is this field intended to capture how the applicant heard about the program and where they obtained their application? Is this field intended to capture any other information?

Answer: There will be a question asking the applicant where they heard about the program. There will be check-boxes for television, radio, newspaper, place of worship, school/day care, doctor's office, organization (specify), and other (specify). This will help us track and manage the outreach effort.

2. If the application can be taken over the telephone, printed by the contractor and mailed to the client for signature, will the Agency provide application stock to print the application on. Or should the contractor's system be able to print an application that is identical to the applications being distributed by the Agency?

Answer: Application stock will be provided by HHSC or its designee.

3. Paragraph states, "Eligibility determination notices and associated enrollment materials must be mailed to families with CHIP-eligible children within 5 business days of the completed application time-stamp." Other states are able to more expeditiously enroll applicants by making the enrollment materials available **with** the applications, whereby; applicants can select their health plan and PCPs on the application submitted to the contractor. This saves the State administrative costs, including postage and streamlines enrollment procedures. Will the HHSC consider allowing this process in Texas?

Answer: As the RFP explains, the generic application is for CHIP, Medicaid, and THKC, each of which have different sets of health plans, cost-sharing requirements, and PCP availability. Consequently, the combined application/enrollment option is not feasible for Texas.

4. The RFP states that "copies of all written applications must be permanently stored through microfilm, electronic imaging, or another appropriate and secure method. This storage requirement will apply for four years from the last active date of the document." Please clarify whether the applications are to be stored permanently (i.e., forever) or for only four years.

Answer: Four years.

5. Where will applications be distributed? What is the estimate of applications distributed monthly?

Answer: Applications will be widely available. Sources will include the administrative contractor's hotline, community-based organizations, health care providers, schools, and retailers. Application distribution has not been estimated on a monthly basis. HHSC recommends proposers contact other populous states with state-designed CHIP programs to learn about their historical experience.

6. Will children of the same family be allowed to enroll with different health plans?

Answer: Yes.

7. The RFP states, ". . . HHSC will develop and produce a generic application for children's health insurance." Will the HHSC consider additional funding if there are significant modifications to the application form?

Answer: The development of the CHIP system will be based on business rules articulated by HHSC or its designee. HHSC anticipates that the joint application will be in its final form by the time this process begins.

8. It appears from the list in the RFP that *HHSC intends that a child's social security number be used as the unique identifier for the child.* Is this correct? If this is

correct, how shall we identify children who do not have social security numbers? In Texas it is likely that children whose parents have never filed income tax could be eligible (e.g. children in colonies).

Answer: This interpretation is not correct. HHSC does not specify in the RFP what unique identifier should be used for each child. The unique identifier will be clarified during the development phase as the business rules are articulated by HHSC or its designee.

9. Will the contractor be responsible for bulk distribution of blank applications to CBOs?

Answer: Yes. The contractor will be responsible for bulk distribution of blank applications to CBOs and other locations where applications are made available.

10. How long does the applicant have to submit the signed application form and/or verifications prior to a follow up letter being sent?

Answer: The timeframe will be clarified during the development phase as the business rules are articulated by HHSC or its designee.

11. Will all CBOs be able to accept data transfers from the contractor in the same formats or will the contractor be required to support multiple formatting of the same file?

    Should the contractor be prepared to send hard copy or other mediums of notice to the CBO?

Answer: The form of notification to CBOs is not specified in the RFP. Letters or faxes are the most straightforward approach, but e-mail is a cost-effective and timely alternative for CBOs that are online. In their proposals, proposers should specify how they intend to notify CBOs, including those that are not online.

12. The list of elements on the application form also includes "Assets, to include the following: -money –vehicles –tangible assets (i.e. home, lot, land, life insurance, etc.)." Does eligibility for CHIP in Texas include an assets test? If not, how is this information to be used? If the applicant does not include information regarding assets, is the application considered incomplete? To what extent is the administrator required to determine if an applicant has provided sufficient information regarding assets?

Answer: CHIP does not include an assets test, but Medicaid in Texas does. This information is on the application to screen children for possible referral to Medicaid. It is incomplete only if the family's income falls within the Medicaid range. Asset verification is not part of the generic application process.

Screening, Eligibility, and Referrals

1. Please explain how the premium subsidy through the Employees Retirement System (ERS) will work. Will the applicant be responsible for submission of the entire premium or will the contractor be required to collect premium payments from both the applicant and ERS?

Answer: The premium subsidy occurs solely through the Employees Retirement System. The administrative services contractor's only responsibility is to identify state employees who fall within the CHIP-eligible income range and notify the employees and ERS of their eligibility for the subsidy.

2. Are applicants permitted to choose CHIP coverage if they are eligible for Medicaid?

Answer: No.

3. The RFP does not discuss how long an application can remain "active" or "open" without becoming "complete." For example, if an application is received without the necessary verifications and the family never sends in that verification, is this application left "active" indefinitely? If the answer is "yes," does the state expect that the administrative vendor system will automatically "age" the children and re-evaluate for eligibility indefinitely? (See question 17, below.) How long must the contractor maintain the application as pending while awaiting additional information from the applicant? Does an application ever "expire," whereby an applicant must fill out another application in its entirety?

   "Application data must be completely entered into the CHIP system within three working days of receipt of a mailed application." It is assumed that this means all data listed on a mailed application must be inputted within three days. However, this application can remain pending in the system indefinitely if necessary verifications are not received. Is this correct?

   How long must an incomplete application remain open before a new application and supporting documentation is required?

Answer: It is not HHSC's intent for an application to remain "active" or "open" indefinitely, particularly as it relates to the activation of automatic system functions like "aging" of a child. The length of time that an application must be held as pending will be determined during system development as the business rules are articulated.

4. The RFP indicates that "the CHIP system must recalculate eligibility status based on. . . ." Is this recalculation only for active CHIP members or for those with pending applications? Does this mean an application that has previously been rejected for enrollment must be considered again, without a new application, by the original applicant's simply placing a phone call to the vendor?

Answer: Automatic recalculation of eligibility status only applies to active CHIP members. If an applicant previously applied and was not deemed eligible for CHIP, and circumstances changed that could affect CHIP eligibility, the applicant must submit a new application, reflecting the new information.

5. Where may bidders obtain additional information about the Employees Retirement System as it applies to their enhanced premium subsidy?

Answer: SB 1351 authorizes the enhanced premium subsidy. The text of the enrolled bill can be found at http://www.capitol.state.tx.us/**.**

6. What are the obligations of the contractor if a family applies and they are not legal immigrants?

Answer: Children who are neither citizens or legal immigrants must be referred to THKC.

7. The RFP presents processing requirements for children of state employees. How will state employees be identified to ensure that applications are processed?

Answer: By matching their employment information on the joint application to a database of ERS-participating entities (principally state agencies). This database will be supplied to the administrative services contractor by ERS.

8. The RFP states, "Copies of all written applications must be permanently stored through microfilm, electronic imaging, or another appropriate and secure method." Will storage of the hard copy original applications be required in addition to microfilming, imaging, or other type of electronic storage?

Answer: Yes. Hard copy original applications must be kept for four years from the date of denial or last activity.

9. May we have a list of DHS offices and their addresses for planning and budgeting purposes? May we assume that to assure delivery within two working days that a delivery service such as Federal Express or UPS will be acceptable? RFP cites that the "original paper application must be sent..." If a proposer decides to image paper documents and store in CD-ROM; would a printed image of the application be acceptable?

Answer: A list of DHS offices can be found on the DHS website at http://www.dhs.state.tx.us/**. Federal Express, UPS, or a similar service will be acceptable. DHS needs the document with an original signature, not a copy.**

10. The RFP states that the CHIP system must track children who have complex special health care needs — specifically, what data must be collected and tracked, and for what purpose?

Answer: Families will be given an opportunity---either on the joint application or during the enrollment process---to designate children with complex special health care needs. This designation must be associated with the child. The health plans will be required to confirm this designation and they will send either a confirmation or a denial back to the administrative services contractor. This confirmation/denial must then be associated with the child. This will enable the state to keep track of how many children with complex special health care needs are enrolled in CHIP.

11. This section refers to client reported changes — is there any mandatory client reporting requirement, and if so how frequently and through what mechanism?

Answer: Mandatory reporting applies to situations involving a change in insurance status. Reporting must be made to the administrative services contractor, either in writing or through the hotline with appropriate verification that the information is correct.

12. We note that the enrollment materials are mailed after eligibility is determined. Will applicants have a certain amount of time to select a Plan/PCP? What actions take place if they fail to select one? Will HHSC entertain any enhancements to this process? If yes, how should potential cost savings be identified in the fee proposal?

Answer: The RFP states that two follow-up letters must be sent to families that fail to select a health plan and pay their enrollment fee (with concurrent notice to a community-based organization). Each follow-up letter must follow the previous action by 10 calendar days. Proposers should respond to this requirement in the manner they believe will be most effective in enrolling families at a reasonable cost.

13. Will eligibility effective dates ever be set retroactively?

Answer: If a child is denied CHIP and the family successfully appeals, eligibility may be established retroactively.

14. Must the database of application and eligibility records contain financial data such as income, expenses, and exclusions? Must the determination of eligibility be based on automated rules rather than desk manuals?

Answer: The CHIP system must contain all eligibility determination data, including income and exclusions. The eligibility determination process must be automated.

15. Will the State conduct routine quality audits of eligible/ineligible determinations? If so, what percentage of applications will the State be likely to choose as a representative sample?

Answer: HHSC has not yet developed a policy in this regard.

16. This section states that verification of income is required through payroll stubs, etc. and also requires verification of childcare costs. What guidelines will the State provide on what is acceptable? If the application is referred as potentially Medicaid-eligible, will the state require that the signed paper application, and the documentation verifying income, child-care expenses, etc. be forwarded or will an electronic transmission of the data fields be sufficient?

Answer: The state will accept a variety of verifications, including payroll stubs, most recent federal tax return, letter from employer, or proof of self-employment income. Other verifications may be identified during the articulation of system business rules. The RFP states that referrals to Medicaid must include transmittal of the paper application to the appropriate local DHS office within two working days.

17. Please clarify the purpose for sending referral application data to the DHS operated Medicaid system as well as e-mail to the appropriate party for notification that the information has been sent. Since the paper application is also required to be delivered to the DHS for purposes of determining Medicaid eligibility, receipt of the paper application should be enough to trigger prompt action to complete processing within the required time frame.

Answer: Electronic referral is necessary to avoid the DHS personnel having to enter data from the written application that already has been entered by the administrative services contractor.

18. Please confirm that an application is considered incomplete if the enrollee fails to select a health plan OR a PCP. The response given during the bidder's conference is different from the written response. (Question #42)

Answer: The application process only applies to eligibility determination. There is no place on the application to select a health plan or PCP. Selection of a health plan and PCP occurs during enrollment, after an eligibility determination has been sent.

19. When does client eligibility for coverage actually begin? Does eligibility occur on the first month only? Can eligibility be retroactive, such as in the case of reinstatement with payment of back premiums?

Answer: The RFP states: "Twelve months of continuous coverage begins on the first day of the month following enrollment unless enrollment occurs after the cut-off date, in which case coverage begins on the first day of the next month." Eligibility can be retroactive only if a child is erroneously denied CHIP eligibility and the family successfully appeals the denial.

Enrollment, Re-enrollment, and Disenrollment

1. Agency specifies a payment coupon book for families above 150% FPL. We suggest that Agency consider mailing monthly billing statements to improve communication with the CHIP member, and ensure that payments are made on amore timely basis. A monthly billing statement provides members with accurate month to month payment information and allows the contractor to be infrequent contact with the member. Please explain why the Agency prefers coupon books over monthly billing statements. Any changes in program qualifications and cost sharing obligations will necessitate the development and mailing of new coupon books which can be costly. How does the Agency intend to reimburse the contractor for this? Is there a projected volume for coupon book changes?

Answer: HHSC believes that a coupon book is a more cost-effective approach than monthly billing. In addition to describing how they will meet the coupon book requirement, proposers are welcome to propose an alternative if they believe it will be more effective in prompting timely premium payments and be more cost-effective. HHSC has not estimated volume for coupon book changes.

2. Are there standards for sending out reminder notices or follow-up letters for enrollment purposes?

Answer: These will be collaboratively developed by HHSC and the administrative services contractor.

3. The RFP states that "the contractor must accommodate changes in health plan enrollment for legitimate reasons such as relocation to a different HMO service delivery area or relocation to a different urban area (necessitating a change in primary care provider)." After a CHIP member makes an initial PCP selection, who is responsible for future PCP changes if a member is not changing health plans, the respective health plan or the administrative vendor?

Answer: The administrative vendor.

4. The RFP discussed information regarding appeal and grievance procedures. Does this refer to the health plans' appeal and grievance procedures?

Answer: This pertains to appeals and complaints related to denial of CHIP eligibility, disenrollment, increases in cost sharing, or denial of a change in health plan.

5. The RFP indicates that "five business days prior to the first day of the month, any contractor must electronically transmit health plan and PCP selections to the health plans. For the purposes of this RFP, this monthly transmittal date is defined as the 'cut-off date.'" Does the state envision that the administrative vendor will transmit

enrollment (not including disenrollment) data to health plans on this date only each month?

Answer: Yes.

6. "Any contractor must also send notice to the family's health plan and a community-based organization participating in outreach in that family's area for follow-up and support." What is the state's intention in transmitting data to a health plan that a subscriber is behind in payment? Is this requirement actually to transmit disenrollment data to the health plan as soon as it possible?

Answer: HHSC's intends that a family delinquent in its cost-sharing obligation be encouraged to become current to avoid the loss of coverage for a child. This includes giving the affected health plan the opportunity to send a letter emphasizing the value of health insurance and the importance of paying the monthly premium. This notice is not intended to be a "pre-disenrollment" notification.

7. (Follow-up question to #8 on the thirteenth page in the *Answers to Questions Pertaining to CHIP Administrative Services RFP* distributed at proposers' conference) The state responded that "based on a child's date of a (sic) birth, the CHIP system must be capable of automatically recognizing when a child's eligibility status changes because of a birthday. This must be an ongoing (as opposed to periodic) function of the system. . . . " Is the state referring to a requirement that effects only enrolled children or does this requirement cover any outstanding application?

Answer: This pertains to both enrolled children and children whose applications are pending.

8. What does HHSC envision for the notification materials? How many different pieces? Do any materials currently exist?

Answer: No materials currently exist. Proposers must determine how many pieces will be needed based on the requirements of the RFP.

9. Do ALL materials need to be updated monthly, or just those that include list of PCPs? Does this refer to the production of printed directories? If so, what is the layout? How many different versions will be expected (i.e. by region, by plan)?

Answer: Just those that include the PCP list. The materials must be designed by the administrative services contractor, subject to HHSC approval. The materials must differ by HMO/PPO service area to reflect the choices of health plans and PCPs available to CHIP-eligible families in each service area. There are 12 service areas (please see the health plan RFP for more information about CHIP service areas).

10. Please indicate the percentage of eligibles that will require Spanish and Braille materials.

Answer: HHSC recommends proposers contact other populous states with sizeable Hispanic populations to learn about their historical experience in this regard.

11. Do notifications go to CHIP and special needs families currently? If yes, please provide copies of notifications.

Answer: Because this question is unclear, HHSC is unable to respond at this time.

12. The RFP specifies that the contractor must send notice to the family outlining the steps for renewal or continuation of coverage. For renewals, must a new application form be completed in its entirety; or would a form requesting a report of any changes in the original application be sufficient?

Answer: HHSC anticipates the use of a streamlined application for re-enrollment purposes. The content and scope of this application has not been developed.

13. While the CHIP Administrator Services RFP specifies that health plans will electronically transmit provider data to the CHIP Administrator on a weekly basis, the Health Plans RFP specifies that HMOs must prepare provider directories. Does HHSC intend that the health plans will print directories and deliver them to the CHIP Administrator for inclusion with enrollment materials? Or, does HHSC expect the CHIP Administrator to create and print the provider directories and include them in the enrollment materials sent to CHIP eligible families? These questions have significant cost implications.

    Please confirm which contractor is responsible for producing provider directories for each health plan.

    If the administrative services contractor is responsible for printing and distribution of the provider directories, how many directories should be printed?

    Is the contractor required to furnish any written health plan/PCP information to families? If so, who develops and bears the cost of printing and distributing these materials?

    Referring to enrollment materials: Is the contractor responsible for producing provider directories and updating these directories monthly as indicated in the RFP? Will the Child Health Plan(s) have any responsibility for this?

    Will the HMO's provide printed provider directories to the administrative services contractor for inclusion in the enrollment package?

Answer: Provider directories will not be included in the enrollment materials; they are provided to an enrollee by the selected health plan following enrollment. The only provider information that must be included in the enrollment materials produced and distributed by the administrative services contractor is the list of available primary care providers associated with each health plan. The enrollment material describing health plan and PCP choices must be designed and produced by the administrative services contractor in consultation with the health plans.

If HHSC determines that materials that comprehensively describe each health plan choice (including the complete provider network) must be included in the enrollment packet, those materials will be the responsibility of the respective health plans. If this determination is made after a contract is executed, HHSC will negotiate an adjustment to the enrollment fee to reflect higher mailing costs based on the weight of the health plan material.

14. The statement is made that "enrollment materials...must be updated...at least once a month." This would be extremely costly. Most HMOs update their directories on a quarterly basis. Would HHSC consider changing the requirement for monthly updates to quarterly updates?

Answer: The monthly updating process only pertains to PCP information when a particular PCP is no longer available. A single sheet of paper noting the unavailability of specific PCPs would meet this requirement; the contractor will not be expected to redesign and republish its enrollment materials each month.

15. Will any other organizations be authorized to determine eligibility for, and enroll children in the Texas CHIP other than the authorized administrator?

Answer: No.

16. Referring to the enrollment process: Can Plan/PCP selections be made by telephone? Is an original signature required?

Answer: Plan/PCP selections may not be made by telephone.

17. How does the applicant receive services during the time between eligibility determination and the enrollment effective date?

Answer: Services are not available under CHIP between eligibility determination and the enrollment effective date.

18. With respect to retro-active disenrollments - will the contractor be required to recoup previous capitated payments from the plans and refund them to HHSC? Or conversely, will an adjustment process be used and if so will the contractor's system be required to process capitation adjustments?

Answer: When retroactive disenrollments occur, the contractor must adjust the aggregate amount due to the affected health plans.

19. Is the contractor required to notify the enrollee by mail if the alternate PCP is selected?

Answer: That notice will come from the health plan.

20. If the family fails to respond to the Open Enrollment notice, they will be disenrolled from their plan. Is disenrollment synonymous with loss of CHIP eligibility? If not, please clarify the difference.

Answer: Disenrollment is synonymous with the loss of CHIP coverage. HHSC interprets this question to refer to the re-enrollment notice. If a family fails to respond to the re-enrollment notice and coverage lapses, the family can re-apply, although that will necessitate filling out the complete application rather than the streamlined re-enrollment form.

21. How will changes in recipient insurance status be communicated to the contractor?

Answer: Families will have the option of communicating change in insurance status either by phone or in writing.

22. How long do clients have to make a Plan/PCP selection? Will eligibility be discontinued if a plan selection is not made? If yes, at what point in time?

    It is understood that if the family chooses a health plan but fails to choose a PCP or an alternate PCP, the health plan will assign the child or children in the family to a PCP. If the family chooses a PCP, but fails to indicate which health plan in an area where there are multiple plans, with PCPs belonging to more than one plan, what is the expectation or procedure?

Answer: Failure to choose a health plan and failure to pay the enrollment fee result in the same effect: the child or children will not be enrolled in CHIP. The RFP stipulates that when a health plan choice or fee remittance is not made, the contractor must send a follow-up notice and subsequent notice if no response is received following the first notice.

Eligibility will be discontinued, necessitating re-application, if a health plan selection and enrollment fee payment is not received within a prescribed period of time. The specific timeframe will be clarified during the development phase as the business rules are articulated by HHSC or its designee.

23. In the response from the Bidder's Conference to Question 3, the Commission indicated that "the administrative services contractor must design, produce, and update – subject to HHSC approval – enrollment materials intended to help CHIP-

eligible families select a health plan and PCP. What constitutes "enrollment materials?" At what point in the process would the contractor be sending these enrollment materials to the family?

Answer: Enrollment materials, which are sent concurrently with the CHIP eligibility confirmation notice, must give eligible families sufficient information to make an informed health plan and PCP choice. They must also describe the cost-sharing responsibilities applicable to a family based on their income. Different sets of cost-sharing material must be produced for each type of cost-sharing arrangement, so that a family receives only the information applicable to their income. In addition, the enrollment materials must describe the appeals and complaints process and the family's responsibility to report changes in insurance status.

If HHSC determines that materials that comprehensively describe each health plan must be included in the enrollment packet, production of these materials will be the responsibility of the respective health plans, although it will be the contractor's responsibility to distribute them. If this determination is made after a contract is executed, HHSC will negotiate an adjustment to the enrollment fee to reflect higher mailing costs based on the weight of the health plan material.

24. Please confirm that disenrollment can occur and be effective at any time during the month. For example, if the monthly premium is not paid, disenrollment appears to be effective as of the cut-off date (5 days prior to month end) for the following month. How does this affect the health plan premium payment?

Answer: A health plan premium payment is based on a full month of coverage. CHIP coverage always begins on the first day of the month. When a disenrollment situation occurs, the health plan receives notice on the cut-off date and coverage ends on the last day of that month. The health plan receives its normal monthly payment for the final month of coverage.

25. Please provide a description of how the default provider (PCP) assignment will work. Will each health plan have a designated "default" PCP and so notify the contractor, or visa versa?

Answer: The health plan RFP stipulates that when a default PCP selection is made, it must be based on proximity of an available PCP to the family's residence. The health plan must notify the administrative contractor of the default selection.

<u>Client Cost-Sharing</u>

1. Client Cost-Sharing indicates that the CHIP system must "provide families an option for cash payment at specific sites." Does HHSC anticipate that the CHIP system will be accessible to staff at these sites so that these payments can be recorded? What organization(s) would be responsible for these other sites? How many sites are

anticipated? How many user staff would the CHIP system be required to support at these sites?

Is the contractor expected to provide for cash payment of monthly premiums at sites other than operations facility?

Answer: The idea behind this requirement is for proposers to develop options for families to make payments at convenient locations. This would be similar to the arrangements some utilities or phone companies have made for customers to make their monthly payments at local banks or supermarkets. The bank or supermarket collects the checks or money orders on behalf of the utility or phone company. HHSC encourages proposers to propose arrangements with specific types of local partners, in which the partners would collect the payments and forward them to the administrative contractor. In turn, the contractor would deliver the payments to the State Comptroller for deposit into the State Treasury.

2. Is the contractor required to maintain a bank account to deposit client cost-sharing funds into? Will the contractor be required to invest client cost-sharing funds and pay interest to the HHSC? Can these funds be commingled with any other HHSC funds held by the contractor?

   Does the bank where the premium funds are held need to be a Texas bank?

Answer: As noted in a previous answer, the adminstrative services contractor does not deposit premiums payments in a bank; the payments are physically delivered to the State Comptroller for deposit in the State Treasury. However, in the case of cost-sharing refunds, the contractor will receive periodic payments from the State on behalf of multiple recipient families and will, in turn, pay the families out of those proceeds. In that situation, the contractor's initial refund payment would be deposited prior to distribution to the recipient families. Any interest earned on these funds prior to distribution must be refunded to HHSC. The funds, which must not be commingled with other funds held by the contractor, do not need to be held in a Texas bank.

3. We recommend that the word "co-pays" in the last sentence of paragraph 2, on page 31, be changed to "cost sharing".

Answer: "Co-pays" is the correct term, since the sole purpose of the ID sticker is to alert providers that no co-payments are due when services are rendered.

4. Is the administrative services contractor or the health plans responsible for designing and producing stickers for exempt status regarding co-pays?

Answer: The administrative services contractor is responsible.

5. The Proposal Deliverable states that the proposer must describe how it will allocate administrative costs to comply with federal cost allocation requirements. What is the exact citation of the federal cost allocation requirement?

Answer: Those provisions of the Federal Acquisition Regulations relating to cost allocation are found at 48 CFR Part 31.

6. The RFP states that "on or about August 20, the selected contractor must notify the family that if the $15 payment is not received by September 10, the children will lose their coverage effective September 25. If payment is not received by close of business September 24, the children are disenrolled and may not be reinstated until January 1, 2001." Shouldn't this read, "if payment is not received by close of business September 10 (as stated in the notification letter), the children are disenrolled effective September 25. . . ."? Or, does the state intend for all disenrollments to occur effective five days before the end of the month, and premiums may be paid up to six days before the end of the following month for premiums due the previous month?

   In the response from the Bidder's Conference to Question 5, the Commission indicated that the payment methodology was addressed in the final version of the RFP in this section. Our interpretation of that section is that an enrollee who fails to pay the monthly premium before the 10th of the second month of coverage without payment will be cancelled at the end of the second month. Is that interpretation correct? If that is true, then we further interpret that the insurance carrier is paid for those two months of coverage; the enrollee is precluded from reinstatement for three months; and upon requesting reinstatement, the enrollee must pay for the two months of coverage outstanding and for the month of reinstatement. Is that also accurate?

Answer: This apparent inconsistency is based on HHSC's desire that families be given the most possible time to make their premium payments prior to being disenrolled. While the notification letter stipulates the 10th (to create a strong incentive for families to promptly respond), HHSC will require the administrative services contractor to accept payments until the day prior to the cut-off date. If payment is not received by that day, the disenrollment notice will be sent to the health plan and CHIP coverage will end on that last day of that month. It is true that the health plan will be paid for the two months of coverage in arrears, the enrollee is precluded from reinstatement for three months, and reinstatement may only occur when the enrollee pays for the two months in arrears and the month of reinstatement.

7. The RFP states that "after it receives a completed form and verifies that the 5 percent or $100 cap has been reached, any contractor must mail to the family a set of stickers to be affixed to the medical ID card of each CHIP-enrolled child. The sticker will identify a child as being exempt from co-pays for the remainder of the calendar year." Is the Texas CHIP benefit year a calendar year, or some other designated twelve month period?

Answer: The reference to "calendar year" has been corrected in an errata sheet posted to the HHSC website. In fact, the $100/5% caps apply to the year of eligibility, not the calendar year.

8. What constitutes an exception to the cost sharing disenrollment policy as defined by HHSC?

Answer: HHSC expects the contractor to incorporate "good cause exceptions" into the CHIP system as the business rules are articulated by HHSC or its designee during the development process. At this time, the exceptions have not been defined.

9. Please provide estimates on the number of families that reach the 5% or $100 limit on an annual basis.

Answer: HHSC recommends proposers contact other populous states with state-designed CHIP programs to learn about their historical experience.

10. The RFP specifies that "any contractor must mail to the family a set of stickers to be affixed to the medical ID card of each CHIP enrolled child." Who will produce the ID cards? How often will they be produced? Who will produce the stickers? How will fraud be controlled?

    This section refers to a set of stickers that are affixed to the "medical ID card" — please confirm that this is the ID card issued by the health plan, and clarify whether there is any requirement for the contractor to issue a CHIP ID card.

Answer: Health plans produce and mail member ID cards shortly after enrollment. The administrative services contractor produces the stickers. New versions of the stickers must be produced on an annual basis. Beyond receiving and reviewing the family's documentation, the contractor will have no additional verification responsibility in connection with the $100/5% caps.

11. The RFP states that "on a monthly basis, any contractor must determine the amount due to each child health plan based on per member/per month premiums and current and retrospective enrollment figures." Will the per member/per month premiums be determined based on the contract between the Health Plan and the State or will it be based on rate cells determined by age, gender, and location or risk adjusted rate cells based on previous or current diagnosis?

Answer: The premiums will be based on contractually stipulated rates for each CHIP health plan. There will be four risk groups for each health plan in each service area. For a more detailed description of the health plan rate methodology, proposers are advised to review the health plan RFP.

12. Are Native Americans self-verified? How will the contractor assure that cost sharing is not applicable?

Answer: Yes. The business rules will be set up to automatically recognize that a self-declared Native American is exempt from cost-sharing and this exemption must carry through all aspects of the eligibility determination and enrollment process, including the enrollment materials and the member ID cards issued by the health plans.

13. Can "notices" be sent to the plan or CBO electronically?

Answer: Electronic notices may be sent to health plans and those CBOs that are online. CBOs that cannot receive electronic mail must be notified by fax or letter.

14. Can a CBO or outreach organization collect premium payments? If so, what is the contractor's responsibility/liability should a discrepancy arise between the CBO and the client?

Answer: The ability of CBOs or volunteer outreach partners to collect premium payments will be clarified as the local outreach strategies are refined and implemented. If HHSC determines that outreach organizations may collect premiums, policies will be set regarding discrepancies.

15. In the last paragraph on the page it is stated that "Any contractor must establish and maintain a separate accounting function for the Texas CHIP program, and all financial documentation and records are to remain segregated from any other business maintained by the proposers." While we understand the concept of separate accounting records, we need a definition of "separate accounting function."

Answer: "Separate accounting function" means separate accounting records and separate audit processes.

16. The TPA is required to produce stickers for the member ID cards to specify that co-pay requirements have been satisfied for the balance of the calendar year. Since each HMO and health plan will be required to produce their own ID cards, the size and placement of the sticker may vary to avoid covering up essential information. The TPA is required to also notify the health plans that the copay limit for the calendar year has been met. Will the state consider moving the requirement for ID card sticker production under the health plan scope of work rather than the TPA?

Answer: No. HHSC anticipates the administrative contractor will work with the health plans to devise a workable and practical way of avoiding conflicts between member ID card and sticker production.

17. There is a reference to the process for handling overpayments, which will be referred to and refunded by the State. In cases where the eligibility premium is paid on a month-to-month basis, will the state consider application of the overpayment to the next month's premium payment?

If premium overpayments are permitted to be applied as a credit to the next month's premium amount, would the member be considered as eligible for services and continuously enrolled if the remainder of the next month's premium was not paid? Would partial payment with balance billing be considered as proof of continued enrollment with no break in coverage?

Answer: The state will consider the option of an overpayment credit during the development process as the business rules are articulated. If this option is pursued, answers to the other questions will be forthcoming at that time.

Appeals and Complaints

1. Does the CHIP Administrative contractor take complaints for all entities working on the CHIP program? (i.e. Marketing contractor, HHSC, CBOs)

Answer: No, only those in relation to its business processes.

On-line Access and Reports

1. "Any CHIP Health Care Provider must also be able to access the system . . . to determine whether a specific child is enrolled in CHIP." The system must be able to "accommodate one million hits per month from health care providers for eligibility inquiries." Is it the States intent to require that health care providers confirm eligibility before providing a service? How many health care providers are anticipated to be web or dial-up enabled?

Answer: Whether eligiblity is confirmed prior to service is at the discretion of each provider. The estimate of 1 million hits is based on historical Texas Medicaid experience. While the number will fluctuate, HHSC anticipates an average of 13,000 providers per month.

2. Refers to including cost information related to alternatives for Ad hoc reports. Does HHSC want cost information contained in the technical proposal, or should this be included and identified separately in the fee proposal?

Answer: The request for additional information pertains to HHSC's expectation that the standardized reporting elements outlined in Appendix A will minimize the need for ad-hoc reports. If a proposer believes this is an unrealistic perspective, they should note that and describe the extent to which they believe ad-hoc reports will be necessary and the associated costs. This cost information should be contained in the technical proposal, specifically as part of the proposal deliverables for the On-Line Access and Reports section.

3. Referencing provider access: Will providers require 24-hour access to the CHIP system? If no, will the separate provider telephone line suffice? Does HHSC envision an interactive voice response or on-line eligibility verification system?

Answer: If a proposer's system will preclude provider 24 hour access, the limits on access should be fully described. As noted in the Call Center and On-Line sections, the administrative services contractor must give providers verification capability through the provider hotline and on-line access.

Electronic Interfaces

1. Electronic Interfaces (page 36) states that "because the State has not yet entered into a procurement with health plans, a dental utilization review contractor, or a quality monitor for the CHIP program, protocols for these additional interfaces cannot be articulated at this time." When does HHSC expect these interfaces to be implemented?

Answer: HHSC expects proposers to describe, in their work plans and timelines, when they will implement their interfaces. HHSC's only requirement is that the all aspects of the contractor's work plan and timeline (including implementation of the electronic interfaces) be consistent with the overall project implementation schedule.

2. What methods of Electronic Interface transmission does HHSC use now? Does HHSC have a preference of transmission method?

Answer: Electronic interface transmission should be done via File Transfer Protocol (FTP).

3. What is the time frame for dental plans and the quality monitor to be selected?

Answer: HHSC anticipates the quality monitoring and dental claims contracts to be executed by the end of 1999.

4. The RFP states that "the state has not yet entered into a procurement with health plans". Is it anticipated that the health plans will provide statewide coverage? If not, how will coverage or access areas be defined? Will there be limits on enrollments based on the access area of a recipient? Will there be limits on access based on the health plan's PCP slots?

Answer: The manner in which health plan coverage will be delivered statewide, and the issues relating to choice of health plans or limits on access are fully described in the health plan RFP.

5. After the State has entered into contracts with health plans, how many additional contractor interfaces are contemplated?

Answer: All anticipated interface requirements are described in the Electronic Interfaces section.

6. What are the contractor's responsibilities with respect to validating provider data received from the health plans? Specifically, is the contractor required to verify and ensure network eligibility, capacity, locations and languages? Will provider data be received only from the plans or will the contractor receive data from other systems or sources?

Answer: Although the contractor will not be expected to verify or validate health plan data per se, reconciliation of health plan data with contractor data will be an ongoing requirement. The health plans will be the primary source of provider data. However, depending on program design, provider data may also be received from the quality monitor and the dental utilization review contractor.

7. The requirements for matching data with the ASVI are unclear. Since citizenship status is self-declared, is the contractor required to run the list of eligibles against the ASVI database to ensure that all legal aliens eligible for coverage have been properly identified and categorized as such? Are there any costs associated with connecting to the ASVI datavase for purposes of eligibility confirmation?

Answer: ASVI database is used to verify alien status. Accessing the ASVI database is an administrative services contractor responsibility as part of the eligibility determination process. It is not a "tape match" process. Rather, it is a system inquiry to verify alien status. If a client claims to be a US citizen, ASVI is not required. If the client is an eligible alien, ASVI is contacted to verify eligibility status. There is a cost for this service. Please contact Nina Medina regarding ASVI cost (512-438-3837).

<u>System Data Handling Requirements</u>

1. "The contractor must comply with any applicable data specification and reporting requirements under the federal Health Insurance Portability and Accountability Act (HIPAA)." HIPAA requires standard data formats for the exchange of Medical eligibility and claim data. Since the contractor will be required to interface with various external entities, will these entities be required to and are they ready to comply with HIPAA standards at the point of implementation? Is DHS MMIS compliant? Will health plans be required to be compliant? Since the federal government has not fully defined and or established complete regulations for EDI regarding HIPAA, which applicable "data specifications" and "reporting requirements" will apply?

   Does the Administrative Simplification requirements of HIPAA apply to this system? If they do, what standards are to be used and for what data transmissions?

According to HIPAA requirements, any entity electronically transmitting claims related transactions (eligibility, claims, remittance, etc.) must use Version 4010 of standard formats from the ANSI X 12N subcommittee. Will the interface requirements for all contractors and other entities sending and receiving data from the TPA be based on ANSI X-12 format?

Answer: DHS is MMIS compliant. HIPAA standards have not yet been finalized by the federal government. Once they are, compliance will be required within two to three years, depending on the size of the entity. In the meantime, data transmission standards for the program must be negotiated between the administrative services contractor and the health plans.

2. What information may the contractor release to community-based organizations as required by the contract?

Answer: Contractor release of information to community-based organizations is limited to the RFP notification requirements (incomplete applications, re-enrollments, cost-sharing delinquencies, etc.).

3. Will the staff of the specified community-based organizations be required to sign confidentiality statements related to their functions for Texas CHIP?

Answer: That will be determined as the role of specific community-based organizations is clarified.

4. What role, if any, will the contractor have in tracking, monitoring, storing, or otherwise managing confidentiality statements?

Answer: The signature line on the joint application will pertain to rights, responsibilities, and authorizations, including releases of information. The contractor will be required to record and track data related to the signature. The contractor will be responsible for maintaining the security and integrity of any information covered by the confidentiality statement.

5. Under the second to last bullet of "Program Assurances," the RFP states, "HHSC will waive the late penalty liability if the proposer's liability is caused by the failure of a third-party to meet a deadline related to the development of an interface described in Section VI(E)(1)(1)." We are unable to locate that reference. Please clarify the reference.

Answer: Interface development and implementation will be a joint effort between the administrative services contractor and the entities with which it is exchanging and receiving data. This is a reference to a situation where the other entity fails to meet its contractual obligations in regard to the development and implementation of an electronic interface.

Section VI(E)(3): Work Plan and Budget

1. Please clarify that the two annual budgets requested should be included in the programmatic response and not in the fee response. The RFP states that as part of its work plan, the proposer must submit two annual budgets outlining anticipated start-up and recurring costs. This appears to conflict with Section III.B.1, which states that the fee proposal must be submitted separately from the technical proposal. Is it the State's intention that cost information be included in the technical proposal? Please clarify.

   This section requires proposers to submit two annual budgets as "part of its work plan," and it appears that the work plan is part of the technical (rather than the fee) proposal. However, proposal submission instructions on page 8 state that the "fee proposal" is to be sealed separately, implying that there should be no cost information included in the technical portion of the proposal. Please clarify where in the proposal (technical or fee) the work plan and the two annual budgets should be presented.

Answer: The annual budgets must be included in the programmatic responses, not the fee response. The fee response is solely related to the State's compensation to the selected contractor and it is submitted as a separate sealed item. The annual budgets are submitted as part of the programmatic response to enable HHSC to evaluate the sustainability and cost-effectiveness of each proposer's proposal.

2. What is the reason for excluding "hotline costs" under the leased space and related utilities category? In what category should these costs be included?

Answer: HHSC agrees the RFP is somewhat unclear in this section. The exception for hotline costs only pertains to fees paid to a long distance carrier or local telephone company. Those costs should appear in the "Telecommunications fees" item. Otherwise, hotline costs can and should be apportioned to the leased space and related utilities category.

3. Will HHSC maintain any other Information System which would validate, verify or reconcile the contractor's CHIP-System data? And would that independent system potentially override or supercede CHIP-System data? If yes, please describe the hierarchy of the system(s).

Answer: The DHS Medicaid eligibility system will exchange information with the CHIP system and there will be data comparisons and reconciliation. Neither that system, nor any other system, will override the CHIP system in matters of CHIP eligibility determination or enrollment.

Section VI(F): Fees

1. In your response to the Draft RFP question (question #9 in Section VI.E.3), you said that certain provisions of the Federal Acquisition Regulations would be applicable to this procurement. Please cite exact provisions of the FAR regulations that will govern this contract.

Answer: Those provisions of the FAR relating to cost allocation (48 CFR Part 31) will apply.

2. The RFP states that it is possible that the state-funded program legal immigrant children will be eliminated and that the contractor must be prepared to modify their systems to move the children to the general CHIP population. Does the cost proposal need to include costs for making these modifications or will the contractor be reimbursed in another manner?

Answer: Whenever program modifications occur that will materially affect the contractor's costs, the State and the contractor will negotiate an adjustment to the fee schedule. Proposers do not need to address this specific contingency in their proposals.

3. The Enrollment Fee per family is based on actual enrollment ant collection of the family's cost sharing obligation. Does this mean that the Contractor will not be paid an enrollment fee if the family does not pay their cost-sharing obligation?

Answer: The contractor will not be paid if the family fails to select a health plan or pay the enrollment fee.

4. Is the sliding scale for the Monthly maintenance fee meant to be an incremental price bid for each additional tier of the table or will the price bid at each tier apply to all enrollees up to that tier. For example, if you bid $1.50 for 1 – 30,000 and $1.00 for $30,001 – 75,000, would the calculation be:

1 – 30,000 x $1.50	=	$45,000	or	75,000 x $1.00
30,001 – 75,000 x $1.00	=	$75,000		
Total		$120,000	or	$75,000

Answer: The manner in which a fee proposal is structured is at the discretion of each proposer.

5. Given that the Call Center and Enrollment processes begin 4/2/00, would the contractor be able to bill 5/1 for enrollments processed in April or is 6/1/00 the first available billing date?

Answer: The RFP states that the "first payment will be payable following the first month of program operation." Because the call center and enrollment processes begin 4/2/00, the first month of program operation will be April, 2000. Consequently, the first payment may be billed on or after 5/1/00.

6. The RFP discusses the application and enrollment fee per family. Please define "family." For example, are families defined as all those living at the same physical addresses, regardless of marital status?

Answer: For the purposes of application and enrollment, a "family" will be the unit upon which the eligibility determination is based.

7. The monthly maintenance fees are applicable only to a number of enrollees. Is it correct to assume that since enrollment is effective up through cut-off in April, for May enrollment that the number of enrollees during the first months will be relatively small due to the mailing process and timing of eligibility versus enrollment?

Answer: The size of enrollment for the first month will be a function of outreach and the speed with which the application and enrollment processes unfold for individual applicant families.

8. How will retroactive disenrollment affect the fees? Will adjustments be made? If so, how will the State make these adjustments?

Answer: Retroactive disenrollment wil not affect the application fee or the enrollment fee. It will affect the maintenance fee. The maintenance fee will no longer be applied to a child following disenrollment in the same way the health plan will no longer be paid a premium for that child.

9. Will families be penalized with additional charges for checks returned from the bank? If not, who will pay the bank charges for returned checks?

Answer: Bank charges assessed in regard to a check returned for insufficient funds are assessed against the account upon which the check is drawn.

10. Will the vendor be required to pay administrative fees for automated payments and credit cards?

Answer: Any estimated costs associated with automated payments and credit cards should be factored into the proposer's fee schedule.

11. Are the Health Plans responsible for reconciliation of their own accounts? Is an electronic data exchange required with each Health Plan to report payment details?

Answer: The monthly enrollment file sent to each health plan will indicate the number of members in each risk group for each service area. Health plans must reconcile this information with their own accounts. This information will be the basis of the amount that will be paid to each health plan on a monthly basis.

12. Will the vendor receive other compensation for special mailings?

Answer: Any mailing costs associated with the RFP requirements should be factored into the proposer's fees. If HHSC adds mailing requirements that are not reflected in the RFP or the contract, additional compensation will be negotiated.

13. Will the State agree to a minimum monthly fee to the vendor regardless of number of applications or enrollees (this is due to a conern that the number of applications will be heavily dependent upon the effectiveness of other parties)?

Answer: No. HHSC recognizes that many parties will affect the application and enrollment rates. However, HHSC believes that the performance of the administrative services contractor in timely processing of applications, development of user-friendly enrollment materials, development of efficient and reliable electronic referral processes, and operation of a user-friendly hotline will be critical factors affecting the application and enrollment rate. A guaranteed payment, regardless of program performance, would be inconsistent with HHSC's intent to link contractor performance to compensation.

14. Will the contractor have the ability to negotiate rates for contract extension years #4 and #5? Does the State plan to include an annual CPI increase for each of the first three-year contract periods as part of the fee reimbursement schedule?

Answer: Proposers may propose fees for contract extension years, although this is not a requirement. If contract extensions are granted, the actual fees will be negotiated at that time. There will be no annual CPI increase for the first three years.

15. The HMO is paid the full premium each month for the next month of coverage. Does that mean that if the member is ultimately disenrolled for non-payment (this process takes up to 55 days from the original premium due date on 1st of month) and the health plan provides services for the second month, the premium would NOT be recouped from the health plan? (Question #62)

Answer: HMOs are not paid for a month of coverage in advance, as the question suggests. Payment to an HMO for a month of service occurs by the first working day following the 14th day of each month. For a complete description of this process, proposers are advised to review Section XVI(E) of the health plan RFP.

Section VI(G): Other Required Forms and Documentation

1. HHSC Certifications (G-5) requires that the proposer complete the "Certification Regarding Lobbying" form (this is provided in the RFP). Disclosure of Lobbying Activities (G-6) states that "this form must be completed to disclose lobbying activities pursuant to 31 U.S.C. Section 1352." Is the form referenced in Section G-5 the same form that is referenced in Section G-6? If not, where can vendors obtain the form referenced in Section G-6?

Answer: If a proposer, pursuant to 31 U.S.C. Section 1352, is required to report lobbying activities, the proposer should request the form referenced in the section from HHSC.

2. Instructions on the bottom of the HUB-SF and the HUB-LOI forms indicate that they are "due 14 calendar days after bid opening date" but the *Good Faith Effort Program (GFEP) for Commodities Open Market* form indicates that "the bidder must submit supporting documentation with the forms listed below within 14 working days following notification of selection by Health and Human Services Commission, but prior to award contract." Please clarify when these are due.

Answer: The HUB-SF and HUB-LOI forms are due 14 days following the day after proposals are due. The GFEP form should be filed as close to that time as is practical, but no later than 14 days after notification that the proposer has been selected for an award or tentative award.

3. *The Determination of Good Effort (DGFE)* form discussed on the *Good Faith Effort Program (GFEP) for Commodities Open Market* is not included in the forms attachments. Please confirm that this form is not required.

Answer: The DGFE form is not required.

4. This RFP section "Other Required Forms and Documentation" requires proposers to submit several different forms, but it is unclear where the state would like proposers to include these forms in their proposals. For example, Section VI.A bullet 10 refers to Section VI.G.2, the response to which would appear in the Technical Proposal, while the order of appearance found in the Proposer's Checklist would indicate that this information should appear in the Fee Proposal. Please clarify whether these forms should appear in the Technical Proposal or the Fee Proposal.

Answer: All required forms and documentation (as listed in Section VI-G) should appear in the technical proposal.

<u>Program Assurances</u>

1. In a Proposers' Conference response the Agency stated that "The fee will be reduced by 1% for every day of delay in the start of operations. That reduction will apply to all fees paid during the first full year of operation" Will the 1% reduction be assessed on the monthly fee or the annual fee? For example, if the monthly fee is $10,000 and the annual fee is $1,200,000, will the 1% reduction be $100 or $12,000?

Answer: $12,000.

<u>Appendix</u>

1. Please clarify the term "service delivery type". From where would this data element be obtained? Where will the contractor receive coding table to identify "parental employer type"? Is this a State defined coding system?

Answer: "Service delivery type" refers to services delivered by an HMO or PPO. This data element will be linked to enrollment in each type of health plan. HHSC or its designee will define the employer codes.

2. Under "Cost Sharing Compliance" please define what is intended under the data element of "premium payment compliance".

Answer: Rate of timely payments and delinquent payments. The actual type of data reporting will be defined as part of the business rules.

3. Please define the specific reporting data elements under "Health Plan enrollment and disenrollment". Will the health plans be required to report this information to the TPA contractor?

Answer: This refers to the number of children enrolled in each health plan and disenrolled in each health plan according to the period being reported. This will be a product of the administrative services contractor's system.